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BULLETIN of the
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THE USE OF PSYCHOANALYTIC PRINCIPLES IN THE THERAPEUTIC MANAGEMENT OF AN ACUTE PSYCHOSIS*

By ROBERT P. KNIGHT, M.D.

Psychoanalysis is not merely a specialized treatment technique for certain neurotic disorders; it is much more important to psychiatry as a body of knowledge and as a scientific approach to the understanding of psychodynamics in mental illness. It provides the opportunity to discover *meaning* in the individual's reactions to his life stresses, and mental illness is simply a maladjustive reaction to life stresses to which a given individual was vulnerable because of his previous life experiences and reaction patterns. The time is past when psychiatrists can be content to describe, label and custodially treat individuals with mental illnesses. The newer knowledge supplied by psychoanalysis has led to a dynamic conception of mental illness and has provided insights which permit looking beneath the surface into the depths of the personality to discover what is happening dynamically to the patient in his life.

On the basis of this dynamic approach it is possible to plan a course of psychiatric treatment which also utilizes dynamic factors in order to reinstate the patient's previous psychological adjustment to life; and in some cases it is further possible to convey insight into his psychodynamics to the patient so that he becomes psychologically stronger after recovery than he was before he became ill.

Every case that is studied and treated from a dynamic point of view has research value and furthers our knowledge as to what the observed reactions and behavior mean in terms of the hidden psychological forces that are operating within the personality. The case to be described was treated successfully at a time (1933) when shock therapy was almost unknown. In many hospitals such a case would today be treated at once by shock therapy—and might be "cured"—without recourse to dynamic understanding of the psychological conflicts involved; but such treatment should be the last resort when the psychodynamic approach fails to achieve a therapeutic leverage.

The following case was studied from the psychodynamic viewpoint but was not treated psychoanalytically, so that there are many gaps in the

* Read before the Topeka Psychoanalytic Society, November 27, 1943.

history, especially in the childhood anamnesis, which prevent confirmation of some of the speculations offered. However, the dramatic nature of the developing delusions, the close time relationship of the symptoms to the life events, and the relatively rapid recovery under a treatment plan based on the presumed psychodynamics make the case worth reporting as a contribution to the literature of psychoanalytic psychiatry. Understanding of the psychodynamics explodes the customary superficial view in such a case that the breakdown was due to the stress of "overwork." The patient was treated only five weeks in the hospital, remained away from home and work for another six months, then returned to his job and has carried on successfully for twelve years.

Case Report

A 42-year-old married but childless banker was brought to the hospital by his wife and younger brother in an acute psychosis characterized by delusions, confusion, intense anxiety and insomnia. He had to be led into the hospital and would not talk, regarding every person and every incident with burning, suspicious eyes. The account of his background and the developing illness was given by his wife.

Background

The patient was the eldest son of a small town banker and had practically grown up in his father's bank. He had two younger brothers and two younger sisters. The next younger brother, two years his junior, had lived in a distant city for several years, but accompanied the patient and his wife to the hospital and was the only person to whom the patient attributed persecutory actions. The patient had finished grade school and high school and from the age of 14 had worked in his father's bank, beginning as janitor. At the age of 26, when this country entered World War I, he had risen to the position of cashier. He entered the Army, went to France but saw no active combat, and was invalided back to this country with a diagnosis of chronic arthritis. He resumed his post as cashier and renewed the admiration and confidence of his associates and of the community. His younger brothers and sisters, toward whom the patient had always shown a paternal attitude, all married and moved away but the patient continued to live with his parents. He was known as an extremely conscientious, reliable person, but one given to "borrowing trouble" and worrying about possibilities that usually did not happen. He functioned as a careful watchdog of the bank's funds and cautiously scrutinized applications for loans and other investments before committing himself. His father, in contrast, was easygoing, rather careless and unsystematic, and a much better mixer socially.

In 1920, when the patient was 29, a bank in a small town seven miles from his home was in bad financial straits through mismanagement and its directors were looking for a capable cashier and managing officer. He was offered the post and finally accepted it. He ran the new bank with a firm hand, twice calling on the stockholders for 100% assessments, and placed the bank on a sound footing. He continued to live with his parents for three more years until, at the age of 32, he married a woman a few months older. He then established a home in the new town but continued to go to see his mother and consult with his father several times a week.

Precipitating Event

Everything went well until the bank moratorium in 1933. The patient's bank had weathered the depression nicely but his father's bank was pretty shaky. The patient's only reaction to the stress of the depression was to become more religious and somewhat more inclined to worry needlessly. He prayed each night with his wife, seeking guidance in handling the bank's affairs and asking for his father's bank to prosper. During the depression there arose some agitation among the customers of his father's bank to induce the patient to return and merge his own bank with his father's, the patient to assume charge of the united banks. He prayed for guidance in this decision. At the end of the moratorium his bank was permitted to open on an unrestricted basis while his father's bank was placed under the 5% restriction. Now the agitation increased for the bank merger, the boards of directors of the two banks conferred, and plans for the merger were drawn. As these negotiations proceeded the patient became more nervous and anxious, lost weight, worked long hours and prayed more fervently for guidance. An additional complication arose when a competitor bank across the street started a whispering campaign to the effect that the merged banks would be unsound because of the weakness of the father's bank—this being an attempt to alienate the customers of the patient's bank, and win them over to the competitor. There was also some customer dissatisfaction at the prospect of their having to drive seven miles to do their banking and the patient worried about this growing hostility. However, the merger plans were completed and one night in May, 1933, the books, files, and funds of the patient's bank were moved to his father's bank and the merged bank opened its doors the next morning with the patient as cashier and managing officer, his father retaining the nominal title of vice-president but being subordinate in authority to the patient.

Present Illness

The merger brought on the acute illness of the patient. There was additional stress on him because of the loose bookkeeping of the original bank

and because of a shortage in the accounts which was finally traced to an old and trusted female employee of his father's bank who had been a schoolmate of the patient. The patient worked night and day and grew more and more anxious. In his nightly prayers with his wife he now prayed for *forgiveness* instead of for guidance. He became convinced that the merged institution was unsound and insolvent. He lost more weight, could not sleep and insisted on going to the bank every day although he became quite unable to take care of the simplest business. He would putter about aimlessly with a worried expression on his face, taking out papers and books and putting them back without accomplishing anything. A physician was consulted who prescribed a nerve tonic and sedatives but he did not improve. He was finally persuaded to go away to his wife's parents' home for several weeks but did not improve and returned still convinced that the bank was insolvent. When the quarterly call for bank statements came out his father made out the report and the patient on seeing it was convinced that it was incorrect. No amount of persuasion or demonstration of figures would change him. Suddenly he seized the statement, went to the phone, and called the state banking commissioner to tell him that the bank was insolvent and he should come and take it over. The statement and phone were snatched from him by his brother, who had been summoned to help, but the patient retrieved the statement, refused to let anyone see it, kept it under his pillow at night and would not talk to anyone. He peered out of the windows at night and thought he saw cars driving up and men circling around to the rear of the house to close in on him and arrest him for ruining the bank. It was at this time, three months after the merger, that he was brought to the hospital.

The patient's wife stated that he had become impotent and had lost all sexual urge since the idea of the merger was first proposed. Their sexual life had been normal prior to this time. Now he did not trust even his wife but felt that his younger brother, who was a sophisticated, worldly-wise person, was conspiring to prevent the patient from purchasing the brother's house and to ruin him. He blamed his brother for getting him locked up and regarded that as part of the persecutory plot.

Course in the Hospital

In the hospital the patient refused to talk to anyone except to answer "yes" and "no." He paced about, restless and suspicious, and pleaded with his wife and with the doctors and nurses to be released. On the third day he presented an entirely different picture. He was animated, smoked his pipe, said he felt fine and was quite talkative. However, he expressed a wealth of delusional ideas. He thought he was the only patient in the hospital—all others being spies and agents of the banking commission

disguised as patients. He said he had written his mother and his wife telling them not to sign anything. He thought the hospital walls were wired with dictaphones to pick up every word he said. Various incidental noises he interpreted as radio signals that had something to do with him. Airplanes were flying over the grounds whenever he was out in order to photograph him. He thought his wife was unfaithful to him with his brother, and in his letter to her he pleaded with her to be true to him. He thought drugs were being put in his food to make him unconscious so agents could enter his room, go through his things and "do things" to him. He stood looking out of the hospital windows and thought every second or third car which passed on the highway was a car from his home town on its way to the State House where the occupants would do him out of his property, and he couldn't understand why they didn't stop in to tell him what they were up to. He thought he recognized his furniture and refrigerator going by on trucks, being taken to the State House to be turned in to make good the bank's losses. He couldn't understand why his wife and family let themselves be swindled out of his property so easily. He demanded that he be allowed to call up his wife and ask about the state of affairs at home. This request was granted, and his wife reassured him that everything was all right except that he was sick. He demanded that an acquaintance who worked in the state banking department come out so he could ask about the details of their having taken over his bank. This request also was granted, and the patient was assured by the acquaintance that his bank was all right and had not been taken over.

That night the patient had an anxiety dream in which he yelled out and thrashed about in bed. He refused the next day to relate the dream but later on said he had dreamed he was accused in court of ruining his father and all his relatives were testifying against him. He again became cautious and non-committal, answered questions evasively and hesitantly, and expressed his delusional beliefs with dogged persistence but without complete conviction. He seemed depressed and said that everything was wrong although he didn't know what he had done to incriminate himself. He wanted to know what we "had on him," and pleaded to be released to go home.

During the remainder of the patient's stay in the hospital he had no more such talkative days, but there was a gradual lessening of his demands to go home and of his delusions, and a gradual lifting of his anxiety and depression. He cooperated fully in the hospital regime, working many hours each day in occupational therapy and in project work. He was a skilled carpenter, as this had been his avocation, and he made numerous pieces of furniture as well as doing a major share of the work in laying the hardwood floor in the recreational center. He was given more freedom

and never violated a single privilege in spite of his less often verbalized but persistent wish to be released. He preferred to remain in the locked building and to eat meals in his room rather than with the other patients in the dining room, although he finally agreed they must be patients and not spies. Daily psychotherapy brought about a somewhat inhibited discussion by the patient of his relationships with his wife, brother and father, and of the events leading up to the merger and he gained some insight. He never included the psychiatrist in his delusions but regarded him as the only person who could help him to get released. Since the way to be released was to obey the psychiatrist he cooperated fully in everything.

Course Since Discharge

After five weeks' hospitalization the patient was released to his wife who was advised to take him to her home in another state, out of all contact with the bank, for three to six months, during which time he should play golf (his favorite recreation), do more carpentry work, rest and if he continued to improve, return to the bank to resume his work. But the family were strongly advised to make certain that the patient took a position subordinate to his father when he took over his job again. All of this was done. The patient regained his weight, worried less, slept without sedatives, worked hard about the house, went out socially, talked less and less about the bank and after six months returned to take up his work as cashier. He has written the Clinic a number of times and whenever he has come to Topeka on business, he has stopped at the Clinic to chat and has seemed happy and well. Each quarter for several years he sent the writer the quarterly bank statement which he, as cashier, had made out and certified.

Discussion

a. Diagnosis

The diagnosis at the staff conference discussion was "acute paranoid schizophrenia," a diagnosis which would seem to be justified by the delusions of persecution and jealousy, the ideas of reference, the illusions and probable hallucinations of vision and hearing. However, the delusions, except for the one day of talkativeness and freedom from bad feelings, never seemed really to possess the patient with conviction. They seemed to persist more like obsessional ideas, and the sense of guilt was never really disposed of through the projection mechanism except for the one day. The strongest disturbed feeling was his sense of guilt, of having sinned, of something being wrong with him and especially with the bank

which was somehow his fault. It was apparent that this "sin," for which he asked God for forgiveness, related to the bank merger, and his reality sense and functioning capacity had not been badly impaired until the merger was effected. Since the merger was not the patient's own idea but one forced upon him by the directors, it was truly a traumatic event—traumatic in a special way for him. It was as if he felt he had been compelled by circumstances to commit the unpardonable sin which brought ruin to his father.

In spite of this deep feeling of guilt and depression the patient did not continue to ask for or expect punishment, as does a patient with a reactive depression. Such a mixture of depressive trends and paranoid delusions is sometimes called "depression with paranoid trends', and sometimes "paranoid state" or "paranoid schizophrenia with depressive trends." The reactive character of the illness and its relatively rapid resolution is more characteristic of a depression than of a paranoid condition, and the continued good mental health of the patient for twelve years following recovery throws some doubt on the idea of its having been a schizophrenia.

Our diagnostic nomenclature is too inflexible to designate such conditions accurately, and we would be better satisfied to give a free lance diagnosis such as "acute reactive psychotic episode, with paranoid and depressive trends."

b. Psychodynamics

The patient's pre-morbid personality was characterized mainly by those features which derive from the anal retentive phase of psychosexual development—compliance, conscientiousness, preoccupation with money and possessions, meticulousness, reaction formations against hostilities, and obsessional fears of danger to himself, his business and his possessions. Also he was chronically constipated and preoccupied with bowel functions and was an habitual user of laxatives.

In his object relationships the patient was a perennial son, closely attached emotionally to his mother, married late to a very maternal woman and never desiring children of his own. Toward his younger siblings he felt paternal and played the role of an accessory father, but his ambition from early childhood was only to "follow in his father's footsteps"—never to outdo or surpass his father. Thus we observe the typical reaction formation against the oedipal wish to rebel against, displace and supersede the father—even to the extent of preserving and protecting the father in his shaky position as banker.

The patient withstood well two periods of stress—one in which he was separated from home and his parents at the age of 26 to be in the Army and overseas for a year or two (although his being invalided out for chronic

arthritis, a condition not observed at physical examination here, might speak for maladjustment in the Army), and the rocky banker's road during the depression years. His stability and psychological reserve were adequate to bring him through these and other types of stress that often affect deleteriously a person of his character structure. Why, then, did a bank merger provide the overtaxing situation which precipitated him into a mental illness?

The answer to this question must lie in the particular nature of this merger. The patient had demonstrated that he could go to another town, take over a shaky bank, put it on a solid financial basis and run it firmly and well. But this time the patient was called upon to move into his *father's* bank and take it over, dispossessing and replacing his father as active head of the bank, and relegating his father to a subordinate position. This corresponded to his deeply repressed hostile wish against his father in the oedipal situation, a wish against which he had erected strong reaction formations. Circumstances conspired to force him to do symbolically the very thing that carried the deepest anxiety for him. He had become strong and his father had become weak and vulnerable and now people wanted him to oust and replace his father. He might have tolerated rescuing his father through advice or through a loan, but he could not tolerate returning to his father's bank in which he had grown up, rising from janitor to cashier, to take a position superior to his father.

To quote the patient's own words in this connection: "It didn't seem the right thing to do to go in and take charge and force my father into an inferior position in his own bank." This line of speculation explains why he felt he had committed a "sin" in effecting the merger and why he prayed to God for forgiveness after the deed was done. It also illuminates the anxiety dream of being accused and testified against in court by all his family—a dream which marked the end of his one day's attempt to get rid of his guilt feelings by projecting the hostility onto unjust persecutors.

The patient's personality reflected a fixation in the negative phase of the oedipal situation—that of passivity and compliance in relation to his father, with repression of heterosexual strivings. It is to be noted, for example, that he did not marry when he had risen to the post of cashier prior to his Army service, nor even after he had resumed this post following his discharge from the Army. He continued to live as a son in his parents' home. Only after he had moved to another town to run a bank of his own did he consider marriage. It may be speculated that strong repressed homosexual tendencies were present—erotic tendencies which operated like his other reaction formations to help keep in check the primary hostility against the father implicit in the earlier positive oedipal phase. When the role of father-attacker was forced upon him by the merger plans this reac-

tion formation of passivity and inhibited homosexuality was undone and he became prey to the original anxiety associated with hostility to the father.

It is interesting to note a slip of the tongue made by the patient in telling of his inability to function at the bank following the merger. In trying to say, "Every time I went to the bank—" he said, "Every time I went to the *back*—" and then corrected himself. It is well known that the passivity of the negative oedipal phase is closely linked with anal eroticism*—especially with the obedience and compliance of the anal retentive phase, which is a kind of reaction formation against the explosive aggressiveness of the earlier anal expulsive stage of psychosexual development. When the individual regresses to the anal sadistic stage, the hostility is often projected, and delusions of persecution—attack from the rear—appear. The persecutors are imagined to be spying and listening (projection of infantile tendencies to spy on and listen to the primal scene), drugging or poisoning the patient to render him unconscious and helpless, and then to be closing in to "do something" to him and take something away from him (i.e., castrate him). Our patient's delusions included all of these elements, but the persecutor was not his father; it was the state banking commissioner (another father image), and his worldly-wise younger brother (who had matured into independence and heterosexual adjustment). The former would take his bank away from him and the latter would take his home and wife away from him—fit punishment for his dispossessing his father from his bank. Thus we see that the patient's reaction to the symbolic meaning (for him) of the merger was an appropriate reaction, for he unconsciously recognized that he was being maneuvered into vanquishing and replacing his father—the very action against which he had so carefully set up his passive defenses.

c. Treatment

Understanding of the above dynamics through psychoanalytic evaluation of the case led to an appropriate rationale of treatment. One had to be satisfied in this case with attempting to restore the previous personality since the patient and his family could not afford prolonged psychoanalytic treatment which might have led to the achieving of insight and the overcoming of the oedipal conflict. The therapeutic aim, therefore, was to reestablish the patient's obedience, compliance and subordination in relation to a new father figure, the psychotherapist. In order to do this the psychotherapist had to stay "inside" the delusional system by acting as the patient's friend and ally, complying with all reasonable demands, and

* Menninger, W. C.: Characterologic and Symptomatic Expressions Related to the Anal Phase of Psychosexual Development. *Psychoanalyt. Quart.*, 12:161–193, April 1943.

arranging to have the disproofs of the delusional beliefs come from authoritative sources outside the hospital. Thus the psychotherapist did not contradict the delusions but permitted the patient to phone his wife for reassurance and to interview first the acquaintance from the state banking department and later the state banking commissioner himself. The latter happened to be an older man who had long occupied a friendly paternal role in relation to the patient. His two visits to reassure the patient that the bank was in good condition, supported by a letter to the patient with the same content (solicited by the writer), were important aids in blocking the further formation of delusions. This left the patient with his sense of guilt to be dealt with, and this was treated with occupational therapy and project work in which the patient was very active and cooperative. The punishment value of confinement in a hospital and banishment-ment from home during hospitalization and for several months afterwards also played a significant part in providing expiation of the guilt feelings. The psychotherapy itself only partially succeeded in giving insight to the patient into his emotional relationship to his father and into the psychological meaning of his fear to supersede him.

The final step was to provide that when the patient returned to his job the whole family should see to it that he occupied a role subordinate to his father even though he might do more work and carry more responsibility than did his father. This advice was religiously observed, and the patient continues to be cashier while his father is vice-president.

Conclusion

An acute reactive psychotic episode is described and interpreted from a psychoanalytic viewpoint in an attempt to show that the decompensation was not due to the "overwork" but was entirely meaningful in terms of the unconscious conflict aroused by the precipitating event. Instead of being a precipitating cause of the illness the overwork represented a desperate attempt on the part of the patient to continue functioning in spite of his intense emotional conflict. The further point is made that application of psychoanalytic principles led both to the understanding of the manifestations of the illness and to an effective treatment rationale based on this understanding.

SHORT PSYCHOANALYTIC PSYCHOTHERAPY*

Second Contribution

By BERNHARD BERLINER, M.D.†

In a previous paper (this Bulletin, 5:204–213, November 1941) I defined short psychoanalytic psychotherapy as a successful first phase of a psychoanalysis which helps the patient to come to terms with his most important problems, but does not forestall a full-course analysis if the case turns out to be one which can not be sufficiently helped with an abbreviated procedure. Whether a long or a short treatment is indicated must be determined by the nature of the case and its development under therapy. The task is to understand as quickly as possible the essential problem in terms of dynamic psychoanalytic psychology and to make it understandable to the patient. The technique, I stated, is preeminently one of ego analysis including the ego-near parts of the super-ego. To-day I may add: it is mainly character analysis and the analysis of interpersonal relations. The analysis of the manifest personality, with which every correct psychoanalysis begins, is in many cases sufficient for a practical result. However, this treatment requires full psychoanalytic understanding on the part of the therapist. The difference, therefore, between this method of short psychotherapy and the classical analysis is of a quantitative, not of a qualitative nature.

In my previous paper I tried to answer the question: how can we define a case as suitable for short psychoanalytic psychotherapy? My first answer was that ego resistances must be at a minimum. The patient must be consciously cooperative and desirous of the treatment, so that we can concentrate on the unconscious resistances or defenses which are the main constituent factors in every neurosis, without encountering conscious unwillingness. If the latter occurs we have to analyze it, of course, and that slows down our pace so that the treatment may become a long analysis.

Transference

Second, I said, there must be a good positive transference during the whole period of treatment, so that no time has to be spent on transference analysis. I was misunderstood on this point and criticized for neglecting the transference analysis as a "loss of time." To avoid this misunderstanding this time I must go into a little more detail. The analysis of the trans-

* From a paper read before the Semi-annual Meeting of the San Francisco Psychoanalytic Society at Los Angeles, October 28, 1944.

† From the Department of Psychiatry, Mt. Zion Hospital, San Francisco, California.

ference is the most essential tool in our psychoanalytic technique. However there is one important rule: as long as the transference is positive and friendly and keeps the patient understanding and cooperative, it is left alone and not interpreted. But as soon as a resistance arises from the transference, we have to analyze it, and we do so under all circumstances, no matter how much time it requires. It is in this point that I see the most important difference between psychoanalysis and short psychoanalytic psychotherapy. If much analysis of transference is necessary to work out resistances and to mobilize the neurotic conflicts, we are doing a full classical analysis. If the case is such that little or no analysis of transference is required on the way to the desired therapeutic result, we are doing a treatment which may deserve the name of short psychoanalytic psychotherapy. But if the therapist, in order to do a short treatment, neglects the analysis of a transference which produces resistances, he does no treatment at all. Of course, in doing analytic therapy, we cannot be satisfied with a relationship that *appears* to be a positive transference or a good rapport. We must look for transference resistances which may hide in a so-called positive transference or may use it as a mask.

In short, cases suitable for short psychoanalytic psychotherapy are those in which the patient can be helped to see and to discuss his central conflict in its own right and in terms of its realities without extensively reliving it or acting it out in relation to the therapist.

Definite indications and contraindications for short psychoanalytic psychotherapy cannot yet be formulated and I doubt if they ever will be. We do not know in advance how a case will respond. One which in the beginning appears severe may respond well to the short method and a seemingly mild case may turn out to be treatable only with a long analysis. Therefore the analyst uses a flexible technique and does not commit himself to either way. In those unfortunately frequent cases in which analysis is needed but for reality reasons is not feasible, we can at least do the best that the circumstances allow. We should be frank and say: short psychoanalytic psychotherapy is indicated in every neurotic case in which psychoanalysis is indicated but cannot be done for reasons beyond our control, and in cases in which there are special contraindications against full analysis, one of which will be mentioned later.

Previously I reported some cases successfully treated with short psychoanalytic psychotherapy. I resist the temptation of adding more of merely confirmatory value and limit myself to presenting some experiences which in my opinion offer some new aspects for the development of this method.

Case Report

A man of 36, a shipyard worker, who came for treatment, gave the following information about himself: He had been married for 10 years, had no

children but described sexual relations as normal. He complained of great anxiety when he had to use a ferry boat, a train or bus and related the fear of the boat to an experience he had had at the age of 17 on an Atlantic crossing when a man on the boat went insane and had to be shackled. The patient was afraid of losing himself, of going crazy and having to be placed by force in a strait-jacket. He described states of depersonalization with an obsessive question "Who am I" and a feeling of not belonging. He was afraid of going to toilets in public places. At the age of 14 he had attended a social occasion of a boys' club, at which boys only were present. He had been overcome by a panicky fear and had wanted to get out but was unable to leave the place. When he was 9, his sister, then 12, died of diabetes. After that, his mother was in a psychiatric hospital for 6 or 8 months.

In the following interviews he reported sexual experiences he had had at the age of 7 with a neighbor girl of 6. They had had sexual intercourse, and the girl had talked about it afterwards. His parents did not discipline him but, to his own astonishment, he could not remember having any emotional reaction at the time—no fear, no guilt-feelings. It became evident that in spite of clear and detailed memories of the incidents his emotional reaction had been completely repressed, isolated During the following years, up to his marriage, he masturbated often which "was not the thing to do." He sought help in religion in vain. But he could recall no emotional conflict about it: again isolation.

On his way to work in his car he had to pick up a fellow worker. He said he was afraid every day as he approached the man's house but he felt better when the fellow was in the car. He felt safe then as if protected by the fellow. The man reminded him of his father. He was afraid of being alone but could not say what he feared. Sometimes he heard a voice calling his name and became afraid. It was a soft, friendly, pleading voice, maybe that of his dead sister. He had slept with her for several years in childhood. There was some doctor game. After recalling this, he remembered some feelings of guilt about having had intercourse with the neighbor girl at 7.

These were, in short, the contents of 14 interviews across the desk during eight weeks. Thereafter he lay on the couch. At the 19th interview the case took a decisive turn. He felt resentment against his wife and was afraid of doing her harm. The doctor game with his sister gave him a panicky feeling: "There was no penis." He was afraid that he might have a desire to kiss a man. He remembered the old hired man on his father's farm. He slept with that man during his boyhood. At that time he sometimes tried to cut his own penis with scissors, but it hurt. He had been told that the stork would take him back and make a girl out of him. Suddenly, on the couch, he got an attack of anxiety and cried: "Who wants to chase me?"

After three more interviews a reconstruction could be made. The man who chased him was the hired man who threatened him with castration for his sexual activities with the little girl. The patient had tried to kiss the man with whom he slept in order to appease him but had then become more afraid because he had feared he would become like a girl to the man and lose his penis. The episode in the boys' club, the experience with the insane man on the boat, and the fear of the fellow worker were derivatives of that old incident. The feeling of depersonalization and the question "Who am I?" meant "Am I a boy or a girl?" The phobia of this patient was the result of a homosexual panic.

After 23 sessions in four and a half months the anxiety spells had completely disappeared and the patient had gained enough understanding that a relapse appeared unlikely. He has not returned yet after almost two years.

Discussion

I learned two things from this case. The first is related to the transference. I expected constantly, and particularly when the incident with the fellow worker came up, that the homosexual conflict would enter into the transference, that the patient would put me in the place of a homosexual love object and re-live his fear of homosexuality and his castration anxiety in relation to me. The resistances caused by this transference situation are among the most stubborn ones we know and they require a long and difficult analysis. But nothing of this kind happened. Although the anxiety broke loose on the couch it had no manifest reference to me. This patient's transference remained throughout the treatment one of distant admiration and unlimited confidence in my ability to help him.

Why was that so? One guess might be this. The patient was a simple farmer's boy with very little education. He worked on his father's farm, then was a hired hand on other farms, then was a helper in a butcher shop, finally took a shipfitter's job to earn the money for his analysis for which he felt a strong sense of responsibility. There were no frank ego-resistances, no secondary gains, only an honest will to be helped against a condition which appeared ego-alien and was to him unbearable. The social and educational distance from the analyst might have been too great to make him a proxy of the hired farm hand of the patient's boyhood.

However, this cannot be a very important factor. I saw the same kind of transference in the young official whose case I reported previously. He was a young man of excellent education and a junior executive in a high government office. His condition was based on a severe father conflict which got him into trouble with his superior in office and about an examination he had to take in order to continue his career. He showed no negative

father transference to me, only the same unlimited confidence which the other patient had had to a good and competent father substitute. He gained insight quickly into his acting out of his old father complex with his environment, he learned that his superior "was not the enemy"; therefore I was all the less so. When the infantile nature of his love life was pointed out to him and he was given the prescription to discontinue it temporarily, he accepted it gladly, without rebellion

I believe the reason for the favorable transference situation in these cases is that both patients had a *high morale*, that is a good sense of reality. They could easily be guided to a testing of reality, and they took an honest stand against a condition which gave them only trouble and no appreciable gain. The practical conclusion as applied to the technique of short psychotherapy would be that we have to encourage the patient's morale, thus defined, and his testing of reality and in this way promote a transference which avoids the necessity of long analytic work on it.

The other thing I learned from this case is the part which is played by the defense mechanism of *isolation* and its importance in the technique of short psychotherapy. All the incidents which the patient reported had been permanently conscious to him. What had been unconscious was the nature of his emotional reaction to them. The *fear* of castration was repressed and displaced. This was the pathogenic force.

In classical analysis we are familiar with isolations in obsessional and compulsion neuroses, but I believe we have not paid enough attention to their occurrence in other conditions. In short psychotherapy this defense mechanism presents itself in a spotlight.

Psychotherapy

Dr. French has referred to "psychotherapy that depends upon confession alone to achieve its results." Confession means telling what one knows about oneself as distinguished from the psychoanalytic method of free associations which in due course brings out what one did not know. Actually there is no great difference. Confession, if it is effective, leads soon to something which the patient knew but of which some essential aspect was not conscious to him. And the unknown that comes back to consciousness with free associations can be used therapeutically only when its meaning for the patient's problem becomes evident; that means when its emotional significance is brought into the focus of the patient's mental activity. This is where the analyst helps with his interpretations and what the psychotherapist does in dealing with the patient's confessions. First we make the patient talk, then we tell him his thoughts and feelings which he cannot verbalize, but we do so at the proper time when he is close to verbalizing them. We point out to him the patterns of his behavior and the types of

his reactions in the light of what he confesses. At the discussion of my previous paper Dr. Norman Reider called this "restating to the patient his problem in more dynamic terms." How does this work? It breaks isolations, the patient "gets the feel of it." What the patient confesses in interviews across the desk is conscious history. What he is not, or not fully, aware of is the nature of his emotional reactions. This we discuss with him. That bridges the isolation, brings the emotional reaction and the incident together again and illuminates displacements and transferences. That is psychotherapy which changes the patient.

Depressive Conditions

I learned to appreciate the importance and the helpfulness of understanding the defense mechanism of isolation in another group of patients which up to recently I did not consider suitable for short psychotherapy. These are persons with *depressive conditions* of the milder form which we treat in our offices.

I have among my patients quite a few women of the climacteric and postclimacteric age who present typical pictures of depression. Well prepared for psychotherapy by the referring sources they come with great confidence. Most of them want analysis.

We no longer consider advanced age alone a contraindication for analysis. However in these cases there may be a special contraindication. I accept for full analysis a woman of this age group only if she is fairly happily married or has some other good contact with a man which offers her normal opportunities for a healthy sexual life. If a woman of this age has no chance for normal sexual gratification (some have never had it) and the whole sexual side of the personality is dormant, an analysis which liberates repressed sexual drives would create a new and insoluble conflict. In these cases we need a selective way which deals with the depression alone.

Abraham has called depression a desperate cry for the love of a good mother. I know of no case of depression, severe or mild, in which this is not the central problem. When the patient tells her life history it comes out very soon that she had, or still has, an unhappy relationship with her mother. If necessary I steer the narrative cautiously to this point. It also becomes evident that the patient constantly behaves as if she were presenting an old unpaid bill, which is the old frustrated claim for motherly love ambivalently blended with resentment and hostility. I follow this up with examples of her every-day attitudes and experiences, and after some more interviews she accepts without resistance that it is the baby in her that cries for motherly love or makes temper tantrums to get it. And the hopeful prediction that this child in her can be eliminated or reduced to more normal proportions and that she will become independent of the hated

mother of her childhood who also survives in her, helps further—if one avoids any reproving or derogatory tone of voice. For consolation I like to quote from Nietzsche that "in every normal man there is a child hidden that wants to play" and add that this is even more true for every normal woman.

The climacteric depression is a regression to a childhood conflict on which there is a fixation. This conflict may remain latent until new actual frustrations due to the circumstances of advanced age, collaborating with neurotic trends in the personality, mobilize the regression and throw the patient back upon the old unhappiness. An old wound is torn open again. We try, of course, to help the patient to restore her life to more actual happiness, but the circumstances may make this extremely difficult, if not impossible. In those cases we can only help her to a brave resignation which she can best achieve by accepting the unchangeable facts of her early life. The problem is of course the same with many male patients.

My results with this group of older patients have been quite encouraging. In these cases I feel that the fact of their advanced age may be utilized in the psychotherapy. It helps to make the patient feel the incongruity between her real station in life and the child in her. I have had less success with this simple technique with younger persons, e.g. a young man with a typical depression due to mother fixation. For external reasons he could see me only a few times; that made me courageous and I gave him the interpretation as outlined in the first interview. He could not accept it and did not come back. This problem may keep us occupied in the treatment of discharged service men.

THE ABUSE OF REST IN PSYCHIATRY*

By KARL MENNINGER, M.D.

A little over a hundred years ago a man was born in Philadelphia who became preeminent in many fields. In 1881 he was described by Sir James Paget as "one of the most distinguished medical men in your country or in any country." In addition to conducting one of the largest private practices in America, he was the author of a book of poetry, one of children's stories, numerous novels, a treatise on neurologic injuries and 250 articles on pharmacology, physiology, toxicology and psychotherapy. He received honorary degrees from Bologna, Edinburgh, Toronto, Harvard, Princeton and Jefferson. It is significant that a man of such prodigious labors and accomplishments should have made famous a program of treatment by rest!

Weir Mitchell described his "rest cure" in a number of books, the titles of which indicate his philosophy: *Wear and Tear, Hints for the Overworked, Fat and Blood.* His idea was that nervous illnesses were the result of physical exhaustion, which he combated by complete bed rest, complete isolation, no visitors, no letters, no reading, no writing; the constant attendance of a nurse, some massage and electricity and, withal, high caloric feeding.

Mitchell's prestige, influence and persuasiveness were such that his "rest cure" for the treatment of neuroses influenced American medicine for nearly fifty years. The fact that persons with nonorganic illnesses who complained of "nervousness" seem to be wasting energy by unnecessary tensions, anxieties and fruitless exertions and that they suffer, subjectively at least, from a high degree of fatigability could not but impress physicians who, because they had been reared and trained in a mechanistic physiologic philosophy of human life, saw these cases without benefit of psychologic insight. The fatigue theory of the neuroses which so impressed Weir Mitchell thus continued to impress nonpsychologically minded physicians, who welcomed a plausible physiologic expansion of these baffling cases. Diagnoses of nervous exhaustion, nervous fatigue, fatigue neuroses, nervous breakdown from overwork, nervous weakness, neurasthenia and so on continued to fill the records of hospitals, clinics and private practitioners. Treatment based on these diagnoses and Weir Mitchell's example were developed, exploited and popularized—modified rest cures, relaxation

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treatment, vacation treatment and what I have called "trip treatment"—the sending of patients away on visits to California, Florida and Europe, or on fishing trips, hunting expeditions and the like.

Modern psychiatry regards this conception of neurosis and these forms of treatment for neuroses as entirely false in theory and unsound in practice. To relate ourselves again to the title of this symposium I will put it this way: the abuse of rest as a treatment in psychiatric conditions represents a neglect or misunderstanding of the real pathologic condition of the neurotic patient under the guise of a treatment which is not only futile and expensive but very often definitely harmful.

Modern Theory of the Neuroses

In the brief limits of time available it would be difficult to answer all the questions to which this statement will give rise. In a very condensed form I shall try to outline the modern theory of the neuroses and of the treatments considered appropriate for them in contrast to those which justify the practice of prescribing excessive rest and indicate, in closing, some of the ways in which rest can be used without abuse.

There is no question but that nervous patients show evidences of fatigue and easy fatigability; this fatigue is a symptom of the neurosis. Overstudy, overapplication, overexertion and all other excess expenditures of energy do not cause psychiatric syndromes; they are often the expression of psychiatric illness. The cure of the psychiatric illness—the neurosis, the nervousness—is the removal of that which impels the individual to make such depletions of his own strength, to waste so much of his energy or to require so much of it to hold himself in check against explosions or collapse. The modern conception of a psychiatric illness is a dynamic one based on a concept of cooperative and interactive anatomy, physiology and psychology. The neuroses and psychoses and other evidence of maladjustment on the part of a patient are a result of misdirected energy rather than the lack of sufficient energy. An automobile the engine of which has become overheated as the result of being driven with the brakes set cannot be cured by resting. As soon as the car's proper function, that of traveling along the road, is resumed (with the brake still set) the same overheating will result. The question is Why are the brakes set and how does one release them?

The problem of treatment of a psychiatric illness thus goes beyond merely arresting any attempt at adjustment by physical exertion. It aims at the redirection of the wasted energy, the removal of interfering inhibitions and the setting up of requisite inhibitions. Human beings are impelled by instinctual forces to attempt certain modifying relationships with respect to their environment. From earliest infancy they want "to do something." As they grow older and the aimlessness of infantile manipulation of the

environment becomes an organized pattern, this something which they do to the environment turns out to be a modification of it in either a constructive or a destructive direction. We perform creative activity and destructive activity—nothing else. Both forms of activity seem to be related to certain instinctual drives, and a certain kind and amount of destructiveness and a certain amount of creativeness appear in the activities of every human being. As long as an adequate amount of both is possible for an individual, he does not develop a neurosis or a psychosis.

For various reasons—a brain tumor, a hemiplegia, an infection with tuberculosis, a reaction of grief to the death of a daughter, a reaction of fear to the treatment of an employer, a reaction of hate to the infidelity of a husband, an ineradicable memory of overwhelming defeat and inadequacy experienced in childhood—for these and many other reasons, the ability to direct energy in a proper pattern of destructiveness and creativeness fails to develop or to be maintained. The resulting incoordinate, awkward attempts to maintain an adjustment is expensive of energy. The patient carries on with his assigned tasks only under the greatest difficulty, with increasing inefficiency, pain and internal and external dissatisfaction. Perhaps he continues to operate at 40 per cent efficiency plus much complaining, worrying, lamenting and despairing, plus many "patent medicines," osteopathic treatments, periods of absenteeism, week end drunks, acerbities with wife and children, quarrels with fellow employees, foremen and assistants. If his efficiency declines even further, let us say to 20 per cent, he may come to a psychiatrist. The brakes are well set, the heat is enormous, the productivity is minimum, the distress is great.

The absurdity and futility of prescribing rest for such a patient must be apparent. The problem is rather to discover what prodigious internal consumption and blockade of energy has occurred and how it can be directed again to fruitful employment. The technic in doing this is beyond the scope of the paper; it would entail a review of the entire program of psychiatric examination and treatment.

"Work Cure"

Pari passu with the development of the rest cure there developed in the field of medicine a program of work cure. This concept held that such individuals needed only to be driven to more strenuous efforts, a procedure comparable to driving an overheated brake-set automobile harder and faster. Obviously, this is an even more absurd philosophy than that of the rest cure. It appealed particularly to hardboiled individuals whose conception of neurotic illness is that its victims are lazy liars or yellow quitters, feigning disability to avoid duty.

At first glance, the behavior of the neurotic or psychotic patient would

seem to lend support to these emotionally colored judgments of the exasperated practical man of affairs. The modern psychiatric hospital provides abundant opportunities for enlisting the interests of patients[1] and yet, despite the efforts of the medical director, the medical staff, the nursing staff and the therapists—despite schedules and regulations and exhortations —many patients manage to evade with an uncanny skill every available opportunity for exercise, constructive craft work, amusement, diversion, recreation and all the other outlets so carefully planned and devised for them. The temptation is to react to this emotionally, forgetting that this is the primary problem of psychiatry. What malignant energy lock has occurred within them that prevents it? What we find almost regularly in psychiatric patients is that they cannot work, they cannot play and they cannot rest. They have to be taught to do all three of these things. Fortunately, in most cases it proves possible to grade the assignments so that patients may be taught to play and taught to work and thus taught to divert available energy toward the construction of patterns of creativeness and destructiveness which can be reemployed usefully in the outside world when the patient has made sufficient progress. Meanwhile of course other types of procedure must be instigated which make more energy available for the development of such patterns.

Treatment By Re-direction

To teach such individuals how to work and how to play is to teach them how really to rest. This is the function of occupational therapy, recreational therapy, educational therapy and psychotherapy as they are employed in the modern psychiatric hospital.[2] They seek to make it possible for the patient to find an outlet for his instinctual urges in work and play properly guided, properly taught, properly selected for his special needs, interests and capacities, and properly graded and expanded. All this is in a contrary direction to that of the old plan of enforced rest whereby the patient through moral, physical or chemical restraint was obliged to surrender to idleness and passivity. Such treatment is not only ineffective; it is actually deleterious because patients deprived of physiologic, mechanical and psychologic devices for turning their aggressive energy into batting a ball, digging a trench or making a puppet turn these destructive tendencies in on themselves.[3] The man who commits suicide, who kills himself, is often thought of as the paradigm of psychiatric morbidity. He turns all of his aggressive energy on himself and commits a murder with himself as the object. It is quite obvious, of course, that many self-destructive persons do not go as far as murdering the object; they only berate it, abuse it, debauch it, humiliate it, hamstring it, intoxicate it. By it, of course I mean the self; this is the way many people treat

themselves. In psychiatry we describe this abuse and mistreatment of the self as the turning inward of aggressive tendencies. The object of psychiatric treatment for such individuals is to turn these aggressive impulses outward, away from the self. Failure to do so results in a virtual suicide, not by placing a gun to the temple or even by pouring gallons of whisky into the central nervous system, but by the accumulation of hostile feelings associated with self-destructive energy that accomplishes the same morbid result. We know that physical exertion, the directed use of the muscles, tends to combat this, and that enforced rest tends to favor it.

This was very vividly illustrated by a clinical phenomenon frequently observed by military psychiatrists in World War II. Soldiers who had been in active combat often for considerable periods would emerge from these sustained exertions and strenuous activity in fairly good condition only to "break down" with symptoms of acute anxiety during the waiting period prior to the next engagement. The literature and the testimony of many medical officers indicate that this was very frequent. This should not be construed to mean that soldiers should be kept in combat unceasingly; this would be a *reductio ad absurdum*. Soldiers need rest and frequent rest but not for the treatment of a neurosis. They need rest for restoring physical and mental reserves. When such rest, however, takes the form of indefinite inactivity, the energies previously expended in combat cannot always be skillfully re-directed or absorbed by some individuals and become self-injurious like a hand grenade from which a soldier has pulled the pin but cannot throw away from himself.

Uses of Rest

Having thus demonstrated as well as I can in the short time allotted to me that rest can be a very dangerous remedy and do a great deal of harm, I should like to end my contribution to this symposium by taking the paradoxical position that rest may also do a very definite amount of good. If one remembers that the psychiatrically disturbed patient who cannot work or play efficiently usually cannot rest adequately, one realizes that definite steps have to be taken to improve this capacity also. It was in that direction that hydrotherapy, prolonged immersion tub baths, wet sheet packs and the like were originally developed, and these are still much employed. Chemical sedatives have improved vastly since the day in which chief reliance had to be put on bromides and opiates. It is possible now to produce sleep in patients whose disturbed emotional conflicts and prevailing fears prevent them from daring to sink into repose. Some sedatives have the peculiar ability, when administered rapidly, so to modify consciousness and the psychologic architecture as to permit the emergence of what might be described as the unassimilated toxic material of the mind. This has been

a feature of recent reports from the war theater made by Grinker and Spiegel,[4, 5] Murray[6] and others. In some instances exposure to prodigious stress, both physical and mental, has so depleted the energy reserves of combat troops, airplane pilots and shipwrecked merchant seamen that psychiatric syndromes characterized by anxiety, fears, aggressiveness, erratic behavior and other symptoms have emerged. In these conditions prompt and complete rest has proved of enormous benefit, as indicated by the reports of Commander Daniel Blain[7] of the War Shipping Administration, Public Health Service Clinics, and his associates.[8, 9] A few nights of sound, protected sleep under quiet, pleasant surroundings with good food and manifest friendliness are often sufficient to restore these individuals to active duty within one to three weeks. Even in these cases, important as is the element of rest, the importance of the psychologic factors of safety, sympathy and admiration are probably equally great. Companionship and planned activities are prescribed as soon as the men are up. It should certainly be borne in mind that these cases represent a war syndrome and are not comparable to any peacetime pictures. There is a vast difference between the man who has worked at full capacity for thirty-six hours without stopping and is then thrown into cold oily waters by a submarine attack and fights for his life in and out of a lifeboat for the next twenty-four hours —there is a vast difference between his need for rest and the need for rest of the average maladjusted, neurotic or psychotic civilian, whose illness is none the less severe but whose physical energy and physiologic defenses have had no such sudden strain put on them.

The observations of the preceding paragraph apply in a very similar way to the use of properly spaced, wisely directed rest periods from combat in the Army. Since this article was written many reports have been made by Army psychiatrists confirming it. In these frequent references are made to the disastrous effects of extended periods of idleness, sometimes erroneously regarded as rest intervals. The deleterious rather than the therapeutic effect of this type of "treatment" is even more conspicuous in those occasional hospitals where an insufficient use is made of occupational therapy, recreational therapy and social therapy.

Finally, the most important application of the thesis of this paper relates to the reemployment of veterans. My brother, Gen. William C. Menninger, in appearing before the Senate banking and currency committee in August (1945) stated that positive assurance of employment to veterans when they become civilians is the best way of preventing medically discharged soldiers from becoming confirmed invalids. Unemployment, he said, will directly contribute to making many of them confirmed invalids and the assurance of sustained employment opportunities was therefore of the utmost importance to the mental health of the nation. When one

recalls that over 400,000 men have been discharged from the Army for what are essentially psychiatric conditions and that nearly one million were rejected from the Army for such reasons one realizes this more fully. As I have tried to outline at greater length in my book *LOVE AGAINST HATE*, work is necessary not only for economic reasons but it is necessary for reasons of mental health.

Conclusion

The concept of rest as a form of treatment in psychiatry arose in an era characterized by the total neglect of the consideration of psychologic factors in the study of human beings. As the mechanistic conception of personality has given way to the dynamic organismic conception, the fallacy of curing psychologic symptoms by merely decreasing muscular activity has become apparent. In the sense of physical inactivity, rest has ceased to be of any importance in psychiatric therapy. Indeed, the tendency is in precisely the other direction; namely, to utilize rather than to blockade further the available energy of the neurotic or psychotic patient. Such a point of view extends beyond a treatment of neuroses and psychoses; in arterial hypertension, for example, where there is a vascular response to the anxiety associated with emotional conflict, the former prohibition of exercise and work seems to have been a step in precisely the wrong direction. I am confident that the death of some hypertensive patients has been hastened by physicians who removed from them the only available or acceptable form of aggression to which they had had access. When I suggested this a few years ago,[10] I received numerous letters from internists confirming this opinion on the basis of their own clinical experience. How widely this may apply to other forms of what we formerly called physical illness and which we now, with equal verbal error, sometimes call psychosomatic conditions has been indicated in part by the presentations in this symposium.

The net philosophical import is that successful medicine must envisage the personality as a physio-chemo-psychologic unit susceptible of being interpreted and treated from the physical standpoint, the chemical standpoint and the psychologic standpoint, assuming a working knowledge of the instinctual motivations that impel the adjustment patterns of human life.

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A BIBLIOGRAPHY ON BIBLIOTHERAPY AND LIBRARIES IN MENTAL HOSPITALS

By JEROME M. SCHNECK, M.D.

Introductory Remarks

A bibliotherapy research project is being conducted at present at The Menninger Clinic. During the course of preliminary investigations regarding the employment of bibliotherapy for neuropsychiatric patients and the structure and function of mental hospital libraries, the author has not encountered as yet any bibliography devoted exclusively to this subject. There are bibliographies covering the field of bibliotherapy and hospital libraries in general and two of these which are especially good are mentioned here. In her book *Hospital Libraries* (32), E. Kathleen Jones has appended a "Bibliography of Periodical Articles" listing 107 titles, but these do not extend beyond the year 1937. In 1931 W. J. Bishop published a bibliography consisting of 133 titles (4). These are divided into seven categories one of which is called "Libraries in Mental Hospitals." Although some overlapping exists only five titles are listed under this division.

In seeking articles dealing specifically with bibliotherapy and libraries for mental patients, one is necessarily handicapped by the fact that some titles do not indicate that the contents deal partly or largely with material in neuropsychiatric institutions. Directly or indirectly the following sources have been utilized: *The Catalogue of the Surgeon-General's Library, Index Medicus, Quarterly Cumulative Index Medicus, Subject Index to Periodicals, Poole's Index* and its *Supplements*, H. G. T. Cannons' *Bibliography of Library Economy, The Reader's Guide*, E. K. Jones' *Hospital Libraries*, and current periodicals which have not as yet been indexed.

The titles listed in this bibliography deal at least in part if not completely with bibliotherapy for neuropsychiatric patients and mental hospital libraries. Those preceded by an asterisk are of greater interest than the others and may be referred to first by readers who have neither the time nor inclination to read all. No further critical evaluation has been attempted at this time because a review of the literature is being planned for publication in the near future.

In view of the fact that much time and effort must be expended in compiling a bibliography of this type, the author hopes it will furnish for those interested in the subject a source of useful references which otherwise would be relatively inaccessible.

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The author is grateful for the cooperation of Miss Clara Louise Meckel, Librarian, The Menninger Clinic, in obtaining many of these articles.

BOOK NOTICES

The Shaping of Psychiatry by War. By JOHN R. REES. Price $2.50. Pp. 158. New York, W. W. Norton & Co., 1945.

This book is the latest in the series of volumes having their origin in The Salmon Memorial Lectures. In essence, it deals with the problems confronting the military psychiatrist, the opportunities for research and progress that have emerged from wartime experiences, the paths along which psychiatry should, and may be expected to, advance, and the significance for civilian psychiatry of the lessons derived from the war. The presentation is stimulating in the extreme, and leads one to agree with the author that "there really is no end to our task, for all the time we shall find ourselves coming afresh to the beginning." In printed form, the volume is an excellent reminder of Brigadier Rees' eloquence and facile speech. (N. R.)

The Neurologist's Point of View. By I. S. WECHSLER, M.D. Price $3.00. Pp. 251. New York, L. B. Fischer Publishing Corp., 1945.

This is a collection of essays previously appearing in various publications, and running a gamut of topics from "The Legend of the Prevention of Mental Diseases" to "On Palestinian and Russian Colonization." The title gives little indication of the contents. No unit goal is apparent; the variety of subject matter is too diverse. The criticism levelled at modern psychiatry appears to the reviewer to be too severe and not altogether warranted. Glimpses into the scholarliness and warmth of the author are the real reward for reading this book. (N. R.)

The Church and the Returning Soldier. By ROY A. BURKHART. Price $2.00. Pp. 204. New York, Harper Bros., 1945.

The author is a minister with some psychological training and much sociological background whose extremely successful church is widely known. In this book he presents some reasons why the church should take an active interest in discharged veterans, including neuropsychiatric cases, and indicates some of the problems they have and the ways in which the church can assist them. (K. A. M.)

Primary Behavior Disorder in Children—Two Case Studies. By Staff Members of the Jewish Board of Guardians. Price 60¢. Pp. 59. New York, Family Welfare Association of America, 1945.

This booklet is devoted largely to two case studies of children diagnosed and treated for "primary behavior disorder" at the Jewish Board of Guardians, New York City. The treatment described represents "a methodology to fit a specific diagnostic category that was developed out of three years of seminars." The plan of working with the parent, sometimes carried along by the child's psychotherapist and sometimes by a caseworker is clearly brought out, although further explanation for this difference would have been welcome. As an illustration of a methodology used in child guidance and related to the child's total situation, and as a description of the interplay of the staff team, the book is purposeful and enjoyable reading, particularly for children's workers. (L. C.)

Psychiatry in Modern Warfare. By Edward Strecker and Kenneth Appel. Price $1.50. Pp. 88. New York, The Macmillan Company, 1945.

This book is divided into two parts, the first being a comparison of the role played by psychiatry in the first World War with that played in the struggle just completed. The authors point out the great mechanical differences in the two wars and the resulting fact that the symptomatology of the psychiatric casualties has become more varied and more intense. The various attempts at therapy are simply reported without any attempt being made by the authors to form any final conclusions. The second section of the book has to do with demobilization and the return to civilian life.

While this survey should be of real value to psychiatrists, social workers, educators and nurses, its orienting value to all interested lay groups should be emphasized. (E. D. H.)

A Psychiatric Social Worker Overseas. By Irene Tobias. Price 50¢. Pp. 45. New York, Family Welfare Association of America, 1945.

This well-written booklet is a summary of the experiences of a Red Cross psychiatric social worker in two overseas military hospitals. It describes how in a unique setting, the adaptable and creative social worker was able to practice old skills, and in addition, discover new ways of being useful. Specific examples of services indicate the personal capacities essential to the overseas social worker in addition to her professional skills. (L. C.)

The Psychiatric Novels of Oliver Wendell Holmes. With Abridgment, Introduction and Annotations: By Clarence P. Oberndorf. Price $3.00. Pp. 268. New York, Columbia University Press, 1943.

Impressed with the psychiatric insight of Oliver Wendell Holmes and his anticipation of some of Freud's psychoanalytic formulations, Doctor Oberndorf has edited three novels by Holmes—*Elsie Venner*, *The Guardian Angel* and *A Mortal Antipathy*—in order to throw into strong relief Holmes' remarkable foreknowledge of modern psychiatric theories. The three novels, almost forgotten in their original form, have been expertly condensed into compact readable case histories. The introduction, commentary and copious, illustrative notes by Doctor Oberndorf point up the parallelisms between the thinking of Holmes and Freud, especially the theme of determinism which is repeated in all the novels.

The study will be useful to students as collateral reading in psychiatry, and of historical interest to many other readers because of its tribute to Holmes and its interpretation of his contribution to modern psychiatric thinking. (J. L. M.)

Total War and the Human Mind. By Major A. M. Meerloo. Price $1.75. Pp. 78. New York, International Universities Press, Inc., 1945.

In seventy-eight pages, this brave, modest psychiatrist, now a Lieutenant Colonel, and a recent visitor to this Clinic, describes his experiences and those of his friends and neighbors during the German occupation of Holland, plus numerous psychological observations derived from this experience.

Dr. Meerloo knows how easily the painful is forgotten and he fears lest this happen so quickly now that new shoots willsp ring up from the roots of Fascism. (K.A.M.)